Results The eHCI overall development score had the largest C-statistic when predicting all three cognitive development measures. For example, when predicting direct assessment numeracy at 6–9 years, eHCI overall development at 2–5 years had the strongest predictive ability (AUC 0.71, 95% CI 0.69–0.73), followed by eHCI numeracy (AUC 0.68, 95% CI 0.65–0.70) and direct assessment numeracy (AUC 0.67, 95% CI 0.65–0.70).

Conclusion Child development at 2–5 years, as measured by the eHCI, was able to predict poor cognitive outcomes at 6–9 years in Lao PDR. Findings indicate we need not rely on costly, individual level direct assessment of early child development. Rather, an adult-reported tool such as the eHCI can be used to identify where supports and greater investments are required to promote children’s later outcomes.

Conclusion This study offers evidence that rising rates of older children entering care were partly driven by cuts to prevention services. These children face significant health and social risks in adulthood. Policies to tackle adverse trends in adolescent care entry should promote reinvestment in youth services, placing ordinary help on a robust statutory footing. We did not find comparable evidence for the younger age group, for whom rising poverty may be more important risk factors for care entry. Limitations, including issues relating to aggregate data, data quality and specification of causal lags, are assessed.

Background Housing has been recognised as one of the most important determinants of health. While there is evidence that housing disadvantage can influence social and behavioural outcomes for children, little is known of the contribution of these pathways to children’s health and wellbeing. This review aims to provide a synthesis of evidence from longitudinal cohort and interventional studies linking experiences of disadvantaged housing in childhood to health outcomes.

Methods A literature search was performed on four databases including Medline (Ovid), EMBASE (Ovid), PsycINFO (Ovid), and Web of Science from 2000 to 2020. Peer-reviewed longitudinal studies assessing the association between housing disadvantage (physical quality, affordability, and instability) in childhood and subsequent physical and mental health were included. The methodological quality of selected studies was appraised using the ROBINS-I (Risk Of Bias In Non-randomised Studies - of Interventions) tool. A narrative synthesis was developed due to study heterogeneity.

Results Forty-five cohort studies met the inclusion criteria. The majority of the studies was evaluated to have a moderate risk of bias. The most studied housing exposure was residential mobility, followed by overcrowding and housing tenure. Other exposures examined in the set of eligible studies include housing facilities (e.g., ventilation, toilet), inadequate heating and self-rated housing condition. Most studies assessed multiple health outcomes, including mortality, respiratory health, substance misuse, subjective measures of health, diagnosed mental disorders, cardiovascular diseases risk factors, and healthcare utilisation. Across the studies, while many relationships remained mixed, consistent evidence of detrimental impact was identified between: poor housing conditions and mortality and self-rated health; inadequate heating and respiratory illness; poor ventilation and all-cause mortality; frequent residential moves and psychiatric morbidity and morbidity. Little evidence is found between overcrowding in childhood and health outcomes.

Conclusion Evidence from longitudinal studies indicates that poor housing experience in childhood may impact health later in life. The findings confirm that housing as a key social determinant of child health, and interventions designed to mitigate housing disadvantage may have significant health gains across the life span.